D Managed Care

This appendix provides information about the following Medicaid and Medicare managed care programs:

- Patient 1st (Reimplementation October 1, 2004)
- Maternity Care
- Medicare HMOs

D.1 Patient 1st

The Alabama Medicaid Agency initiated a Primary Care Case Management (PCCM) program in Alabama known as Patient 1st. The Program began January 1997 and was terminated February 2004. It was then reinstated effective October 1, 2004.This medical program operates under a "freedom of choice" waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (b) of the Social Security Act. In a PCCM program, a physician contractually agrees to deliver and coordinate health care for patients who select or are assigned to the physician as their Primary Medical Provider (PMP).

Patient 1st will be active in all counties by January 1, 2005.

Counties participating in the Patient 1st program were phased in over a two-year period beginning with Marengo county on January 1, 1997. With the addition of Mobile County on June 1, 2000, all counties now participate.

D.1.1 Recipient Eligibility

All Medicaid patients are required to present proper identification to providers of medical care services. To verify eligibility, providers should access Medicaid's Automated Eligibility Verification and Claim Submission (AEVCS) system or the Automated Voice Response System (AVRS) as explained in Chapter 3, Verifying Recipient Eligibility.

These systems indicate whether the recipient is enrolled in Patient 1st and provide the name and phone number of the Primary Medical Provider (PMP). Providers should be aware that Medicaid will not cover non-emergency services provided to Patient 1st participants unless they are approved by the patient's PMP. To obtain approval of care, the provider must contact the patient's PMP. It is the responsibility of the provider to verify eligibility before providing treatment or services under the Medicaid program. Emergency care services in the outpatient hospital setting are covered under the requirements of the Balanced Budget Act of 1997 using the prudent lay-person definition. Physicians must certify that the visit meets this definition.

At present, the following individuals do not participate in the Patient 1st program:

- Foster children

- Recipients who have both Medicare and Medicaid
- SOBRA adults
- Those enrolled in private Managed Care plans
- Recipients who reside in a long term care facility
- Children certified through Department of Youth Services (DYS) county 69
- Recipients who are lock-ins
- Recipients whose Medicaid eligibility is retroactive only
- Recipients who have been determined medically exempt

  (See Chapter 39 of the Medicaid Provider Manual for a list of possible exemptions)

D.1.2 Assignment of the PMP

Most Medicaid patients are required to participate in the Patient 1st Program and to select a Primary Medical Provider (PMP). Typically, PMPs are general and family practitioners, pediatricians, internists, OB/GYNs, federally qualified health centers and rural health clinics that provide a “medical home” through an ongoing patient-physician relationship.

Patients are assigned to a PMP based on newborn information, siblings, last PMP, historical patterns of care, location, and other variables. Each recipient receives a letter and welcome packet 30 to 45 days prior to their enrollment effective date. The letter indicates the PMP they have been assigned, the effective date of enrollment, and how to change PMPs if they choose. The welcome packet includes educational materials and a county specific Patient 1st Provider List. Patients may select or change PMPs monthly by calling Medicaid at 1-800-362-1504.

Newborn Assignments

The Newborn Assignment Form (Form 354) is used to request assignment of the newborn's physician. The Managed Care Division collects these requests and sends them to EDS for assignment on a monthly basis. Forms are available by contacting Medicaid’s Customer Service Unit at (800) 362-1504. Copies of these forms may be made as needed. Requests may also be faxed to the Customer Service Unit at (334) 353-5556.

D.1.3 Referrals

PMPs provide (or authorize others to provide) primary and preventive care and certain other services as outlined in the Patient 1st Provider Manual. PMPs coordinate patient referrals to specialists and offer 24-hour availability for care or referral.

PMPs continue to bill Medicaid on a fee-for-service basis for all direct care. In addition, PMPs receive a monthly fee ($3 per month per patient) for managing the patient’s care, up to a maximum of $3,000 per month.

Referred Services

All services, except those listed below, require a referral from the PMP in order for Medicaid to reimburse payments. **For services that require a referral, providers must indicate the referral information on the claim form**. You do not have to submit a copy of the referral with the claim, and these claims can be billed electronically. The referral must be documented in the patient's medical records. Refer to Appendix E, Medicaid Forms, for sample Patient 1st referral forms.

Services That Do Not Require A Referral

Some services are not included in the Patient 1st program. For these services, patients can choose to receive care from any Medicaid-enrolled provider.

The following table lists services that **do not require a referral** from the PMP:

Service	***Claim Type***
Allergen/Immunotherapy	Medical
Ambulance	Medical
Anesthesia (ASA procedure codes only)	Medical
CRNA	Medical
Dental Care for Children	Medical
EEG/EKG Related	Medical, Outpatient
EPSDT Intensive Evaluation	Medical
Factor 8	Any Claim Type
Family Planning	Medical, Inpatient, Outpatient
Glucose Test Strips/Lancets	Medical
HCBS Waiver	Medical
Health Education Prenatal Classes Adolescent Pregnancy Prevention	Medical
Hearing Aids	Medical
Hospice	Outpatient
Hospital – Inpatient	Inpatient
Hospital – Outpatient for: Chemotherapy Certified Emergency Lab Services X-Ray and Lab	Outpatient
Hospital – Psychiatric	Inpatient
Immunizations	Medical, Outpatient
Independent Labs	Medical
Independent Radiology	Medical
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Inpatient
Long Term Care (LTC)	Inpatient
Maternity Services	Medical, Inpatient, Outpatient
Mental Health Rehab Option	Medical

Service	*Claim Type*
Nephrologists (End Stage Renal diagnosis only)	Medical
Non-emergency Transportation	Medical
Nuclear Medicine	Medical
Nurse Midwife, for office visits	Medical
OB/GYN	Medical, Outpatient
Ophthalmologist (Routine eye care only)	Medical
Optometry (Routine eye care only – glasses)	Medical
Oral Surgeons	Medical
Orthodontia	Medical
Pathology	Medical
Pharmacy	Medical
Physicians, for certain services	Medical
Professional Component	Medical
Prenatal Clinics	Medical
Renal Dialysis	Outpatient
Targeted Case Management (does not include Targeted Case Management for medically at risk)	Medical

D.1.4 Patient 1st Billing Instructions

This section provides billing instructions specific to Patient 1st and EPSDT-referred services. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

- Block 2 – Enter the referring PMP's nine-digit provider number
- Block 24 – Enter "**X2 or X3**" to indicate Patient 1st

If you file **electronically** on the UB-92 (837 Institutional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file hard copy claims on the **CMS-1500**, you must complete the following fields:

- Block 17 – Enter the name of the referring Primary Medical Provider (PMP)
- Block 17a – Enter referring PMP's nine-digit provider number
- Block 24h – Enter "**3**" indicating Managed Care

If you file **electronically** on the CMS-1500 (837 Professional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

EPSDT and Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

- Block 2 – Enter the referring PMP's provider number
- Block 24 – Enter "**X3**" to indicate EPSDT and managed care

If you file **electronically** on the UB-92 (837 Institutional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file hard copy claims on the **CMS-1500**, you must complete the following fields:

- Enter the name of the referring Primary Medical Provider (PMP) in block 17.
- Enter referring PMP's nine-digit provider number in block 17a.
- Enter "**4**" indicating EPSDT and Managed Care in block 24h.

If you file **electronically** on the CMS-1500 (837 Professional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you have program or policy questions about Patient 1st, contact Medicaid's Managed Care Division at (334) 353-5773.

Certified Emergency Services

Hospitals and physicians who provide outpatient certified emergency services are not required to have a referral from the PMP. All related services for the emergency condition (provided on the same date of service), including those provided by a specialist, may be billed directly to EDS without a referral.

If you file hard copy claims on the **UB-92**, enter an "**E**" in block 78.

If you file electronically on the UB-92 (837 Institutional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file hard copy claims on the **CMS-1500**, enter an "**E**" in block 24i.

If you file electronically on the CMS-1500 (837 Professional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file your claims electronically using a software vendor, you should obtain information directly from your vendor regarding where to place referral information.

For more detailed information on the Patient 1st Program please refer to Chapter 39 of the Medicaid Provider Manual.

D.2 BAY Health Plan

This program was terminated October 1, 1999.

Effective May 1, 1997, the Alabama Medicaid Agency initiated a managed care system for most Medicaid patients in Mobile county. The program, called BAY (Better Access for You) Health Plan, is administered by PrimeHealth, an Alabama-based health maintenance organization affiliated with the University of South Alabama.

This system operates under a Research and Demonstration waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1115 of the Social Security Act. The waiver was approved for five years and may be renewed with CMS's approval.

BAY Health Plan represents a network of traditional health care providers in the community along with other existing resources in order to ensure adequate access to care for Medicaid patients. BAY Health Plan includes the University of South Alabama hospitals and physicians, private physicians, the Franklin Memorial Health Centers, the Mostellar Medical Center, the Mobile County Department of Public Health, Mobile Infirmary, and other providers in the Mobile area.

The Customer Service number for BAY Health Plan is 1-800-894-2291.

Assignment of the PCP

Under BAY Health Plan, Medicaid patients select a primary care physician (PCP). If the recipient does not select a PCP, one will be assigned by the Plan. Participating PCPs provide a "medical home" through an ongoing patient-physician relationship and must provide, arrange, or authorize all care except emergency services, family planning, and Medicaid-covered services. Patients may change PCPs monthly by contacting BAY Health Plan.

Recipient Eligibility

BAY Health Plan participants are required to present both their Medicaid card and their BAY Health Plan card at each visit to obtain health care services or medicine.

To verify eligibility, providers should access Medicaid's AEVCS or Automated Voice Response System (AVRS) referenced in Chapter 3, Verifying Recipient Eligibility, of this manual. These systems indicate whether the recipient is enrolled in the BAY Health Plan. Providers outside the BAY Health Plan network should be aware that BAY Health Plan and Medicaid will not cover non-emergency services provided to a BAY Health Plan participants unless they are approved by the Plan. Prescription medication is subject to a formulary and exceptions must be approved by the BAY Health Plan.

Most Medicaid recipients are required to participate in the BAY Health Plan. The following individuals do not participate in the BAY Health Plan:

Children certified through the Department of Youth Services (DYS) County 69

Foster children

Recipients with Medicare and Medicaid

Those with private HMO coverage

To contact the patient's PCP, refer to the number on the patient's BAY Health Card. For additional assistance 24 hours a day, contact the BAY Health Plan at 1-800-894-BAY1 (2291).

It is the responsibility of the provider to verify eligibility before providing treatment or a service under the Medicaid program. Claims for services provided to BAY Health Plan participants should be filed directly with the BAY Health Plan except for the following services, which should be filed directly to Medicaid:

- Long Term Care Facilities
- Targeted Case Management provided by the Department of Human Resources
- Home and Community Based Services (HCBS) waiver
- Services provided by the state laboratory
- Rehabilitation option services through the Department of Human Resources
- Transplants other than retina and cornea
- Non-Emergency Transportation
- Eyeglasses

If you have any questions regarding this program, contact Medicaid's Managed Care Division at (334) 353-5773.

Medicare Complete

D.3 Medicare HMOs

The Alabama Medicaid Agency's Medicare HMO Managed Care program began January 1, 1998. At that time United HealthCare and the Alabama Medicaid Agency entered into an agreement whereby Medicaid would make a capitated payment to United HealthCare to cover Medicare cost sharing of certain Medicaid eligibles enrolled with the Medicare HMO.

This program has now expanded to include three Medicare HMOs approved by CMS (Center for Medicare and Medicaid Services) to operate in Alabama – United HealthCare's Medicare Complete, Viva Health's Medicare Plus, and HealthSpring's Seniors First. At least one Medicare HMO is receiving

capitated payments for certain Medicaid eligibles living in the following counties – Blount, Jefferson, Shelby, St. Clair, Bibb, Chilton, Walker, Baldwin, and Mobile. Additional counties may be added to Medicaid's Medicare HMO Managed Care program as these Medicare HMOs expand their coverage.

D.3.1 Enrollment

Enrollment in a Medicare HMO Plan is voluntary. Recipients who enroll in a Medicare HMO must select a primary care physician affiliated with the HMO who will provide or authorize services. To contact the patient's primary care physician, refer to the number on the patient's Medicare HMO identification card. Providers should be aware that non-emergency services provided to a Medicare HMO participant will not be covered by the Medicare HMO unless approved by the patient's primary care physician.

Recipients may disenroll from a Medicare HMO at any time by submitting a written request to the HMO. Recipients who disenroll within the month will have Medicare HMO coverage through the last day of that month.

Patients with questions about enrolling in a Medicare HMO should call the HMOs directly.

D.3.2 Recipient Eligibility

Medicaid's Medicare HMO Managed Care program is open to those Medicaid recipients who have both Medicare and full Medicaid (dual eligibles) or who have Qualified Medicare Beneficiary (QMB) only coverage. In addition, eligible individuals must be enrolled with a Medicare HMO that participates in Medicaid's Medicare HMO Managed Care program. Once the Medicaid Agency is notified by a participating HMO of an individual's enrollment, Medicaid will make a capitated payment to the Medicaid HMO for each following month of coverage as long as the individual remains eligible for enrollment.

Medicare HMO participants should present both a Medicaid card and a Medicare HMO identification card; however, it is the responsibility of providers to verify eligibility before providing treatment or a service under the Medicaid program. Therefore, providers should closely question individuals who reside in counties where Medicare HMOs are active to determine the type of Medicare coverage. To verify Medicaid and Medicare eligibility, providers should access Medicaid's eligibility systems as explained in Chapter 3, Verifying Recipient Eligibility. These systems indicate whether the patient is enrolled in a Medicare HMO, and the managed care section of the eligibility response will indicate whether the individual is enrolled in Medicaid's Medicare HMO Managed Care program.

D.3.3 Covered Services

Services covered by the Medicare HMO include those services covered by Medicare. Medicare HMOs may also provide certain additional benefits to eligible persons:

- Unlimited hospital days
- Annual physical exams
- Hearing exams
- Dental coverage – Shelby and Jefferson counties only
- Non-Emergency Transportation
- Some immunizations

Claims for services provided to Medicare HMO participants are to be filed directly with the HMO.

Medicaid's capitated payment covers all Medicare cost sharing for eligible individuals who are enrolled in a participating Medicare HMO. Therefore, neither Medicaid nor the recipient will pay any co-payments, coinsurance or deductibles for Medicare services incurred during the time that the individual is enrolled in Medicaid's Medicare HMO Managed Care program.

Medicaid-only covered services that are not a part of the Medicare HMO (for example, drugs) are covered on a fee-for-service basis by Medicaid. Providers must submit claims for these services directly to EDS. Providers may collect copayments for services covered only by Medicaid.

If you have program or policy questions about Medicaid's Medicare HMO Managed Care program, contact Medicaid's Third Party Division at (334) 353-4542.

D.4 Maternity Care

The Alabama Medicaid Maternity Care Program provides locally coordinated systems of care in which targeted populations receive maternity care in environments that emphasize quality, access, and cost-effective care.

The purpose of this managed care effort is to ensure that every pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health.

The Alabama Medicaid Agency selects primary contractors for the Maternity Care Program through a competitive bid process. Contractors must meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to the *Maternity Care Operational Manual* published by the Alabama Medicaid Agency for further details.

D.4.1 Districts

Medicaid has established fourteen maternity care districts, and primary contractors must show that a care system operates in the entire district. Contractors are required to provide maternity care services to all women eligible for maternity care in the specified district.

Providers should advise recipients that if they knowingly and intentionally go outside of the provider network for non-emergency care, the recipient must pay the bill if they do not get approval from the primary contractor. The districts are as follows:

District	***Counties***
District 1	Colbert, Franklin, Lauderdale, Marion
District 2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
District 3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
District 4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
District 5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
District 6	Clay, Coosa, Randolph, Talladega, Tallapoosa
District 7	Greene, Hale
District 8	Choctaw, Marengo, Sumter
District 9	Dallas, Wilcox, Perry
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
District 11	Barbour, Chambers, Lee, Macon, Russell
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
District 13	Coffee, Dale, Geneva, Henry, Houston
District 14	Mobile

D.4.2 Eligibility

The following recipients are required to participate in the Maternity Care Program:

- SOBRA recipients
- Those certified through the Medicaid for Low Income Families (MLIF) Program (formerly AFDC)
- Refugees
- SSI eligible women 19 and over

The following recipients **are not** required to participate:

- Dual recipients (Medicare/Medicaid)
- Indians who are members of a federally recognized tribe
- Children under the age of 19 who meet any of the following criteria:
  - Persons eligible for SSI under Title XIX
  - Persons in foster care or other out of home placement such as Department of Youth Services (DYS)
  - Persons receiving foster care or adoption assistance

  - Persons receiving services through a family-centered, community-based, coordinated system of care receiving grant funds (Special Needs)

- Recipients enrolled in a private HMO
- Those persons described in Section 1902(e)(3) of the Act

Medicaid recipients who are not required to participate may participate on a voluntary basis, with the exception of dual eligible recipients (Medicare/Medicaid). If the recipient elects to participate in the program, Medicaid pays for services through the Maternity Care Program.

Providers can obtain Maternity Care enrollment information through Medicaid's automated eligibility systems, AEVCS and AVRS, as described in Chapter 3, Verifying Recipient Eligibility.

D.4.3 Covered Services

The primary contractor is responsible for all pregnancy-related care that occurs during the period before birth, at the time of delivery, and postpartum. Medicaid pays a global fee to the primary contractor for each recipient.

Claims for services covered under Maternity Care should be filed directly to the primary contractor for payment. In addition, hospitals are required to submit inpatient delivery claims directly to EDS for processing as encounter data (no payment, used for reporting purposes only).

The following services are covered under the Maternity Care Program.

- Antepartum care
- Delivery
- Hospitalization
- Outpatient care (except emergencies)
- Postpartum care
- Care coordination services
- Assistant surgeon fees
- Associated services
- Anesthesia services
- Home visits
- Ultrasounds (the first seven u/s per pregnancy)

Ultrasounds

Medicaid pays for obstetrical ultrasounds for reasons of medical necessity. Payment will not be made by Medicaid to determine only the sex of the infant.

Primary Contractors in each district are financially responsible for the first seven ultrasounds for each pregnancy. Medicaid's Prior Authorization Unit (PA) has the ability to authorize additional ultrasounds (number 8 and above)

based on the recipient's clinical condition. Ultrasounds approved for payment by the PA Unit will be paid by Medicaid fee-for-service.

The following required information shall accompany all ultrasound requests for authorization:

- Date of the requested ultrasound
- Date of the request
- A list of all dates of prior ultrasounds for the current pregnancy (for all providers that have performed ultrasounds)
- Recipient's date of birth and Medicaid number
- EDC-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

PA requests shall be submitted to EDS following normal PA procedures.

D.4.4 Separately Billable Services

Certain maternity care services are not considered part of the global fee. The following services may be billed directly to Medicaid on a fee-for-service basis:

Separately Billable Service	***Description***
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron).
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests.
Dental	Dental services are covered for recipients under 21. For SOBRA-eligible recipients, services must be pregnancy-related.
Physician	Physician fees for family planning procedures (for example, sterilization). Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number, and will be paid fee for service.
Family Planning Services	Any claim with a family planning procedure code or indicator, with the exception of hospital claims for sterilization procedures performed during the delivery stay may be billed on a fee-for-service basis.
Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the expanded global fee. Access to emergency services will not be restricted by the Maternity Care Program.
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.

Separately Billable Service	*Description*
Fees for Dropouts	All services provided to dropouts should be billed fee-for-service. However, the provider of service must submit the claims to the Primary Contractor for Administrative Review. Appropriate claims will then be referred to Medicaid by the Primary Contractor.
Mental Health	Mental health visits for the purpose of outpatient mental health services may be billed on a fee-for-service basis.
Miscarriages at less than 21 weeks	All services may be billed fee-for-service. If the claim does not contain the miscarriage diagnosis code, it must be sent to the Primary Contractor, who must submit an Administrative Review Form to the Alabama Medicaid Agency prior to the services being billed fee-for-service,
Referral to Specialists	Services provided by non-OB specialty physicians (such as cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner and perinatalogist are not considered specialty providers.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service. The Primary Contractor must submit an Administrative Review Form to the Alabama Medicaid Agency and obtain approval for the exemption prior to the claims being billed to avoid denials of the claims.
Non-Pregnancy Related Care	Services provided that are not pregnancy-related are the responsibility of the beneficiary unless she is eligible under regular Medicaid benefits.

D.5 Completing the Claim Form

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

D.5.1 Time Limit for Filing Claims

Medicaid requires all claims for managed care services to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

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